No. 00-1471

Supreme Court, U.S.
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In The
Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,

Petitioners,

v.

JANIE MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF *AMICUS CURIAE* OF THE AMERICAN COLLEGE OF LEGAL MEDICINE IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether Kentucky's Any Willing Provider statute is preempted by ERISA if it does not relate to employee benefit plans or, is it saved from preemption because it regulates the business of insurance by regulating the practice of medicine?

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BRIEF *AMICUS CURIAE*

INTEREST OF THE *AMICUS CURIAE*[1]

The American College of Legal Medicine ("ACLM") has been in existence for 43 years and is an educational, non-profit organization with over 1300 members. It is the only organization of its kind in the sense that the majority of its members hold dual degrees in medicine and in law. Its membership also consists of attorneys, physicians, nurses, those in health care administration, in government service and those who hold full time academic positions in health care and health care law.

The mission of the ACLM is to educate, train and advance dialogue and discussion for those who have a sustained interest in issues at the crossroads of law, medicine and health care law. This includes promoting the administration of justice and assisting jurists in issues, such as the ones presented in this case.

SUMMARY OF ARGUMENT

Kentucky's Any Willing Provider ("AWP") statute is not preempted by ERISA because it does not relate to an employee benefit plan ("EBP"). If this Court determines that the statute does relate to an EBP, the statute is saved

[1] Petitioners and respondent have filed global consents to the filing of all *amicus* briefs in this case. No counsel for a party authored this brief in whole or in part. No persons or entities other than the *amicus* made a monetary contribution to the preparation or submission of this brief.

from preemption because it regulates the business of insurance by regulating the practice of medicine.

The AWP statute does not relate to an EBP because it does not have a connection with, or a reference to, an EBP sufficient to trigger preemption. There is no connection because the statute does not directly affect an EBP nor does it bear indirectly but substantially on an EBP. There is no reference to an EBP sufficient to trigger preemption because the statute does not act immediately and exclusively on an EBP nor is the existence of an EBP essential to the law's operation.

Further, in the alternative, the AWP statute is saved from preemption because the statute regulates the business of insurance by regulating the practice of medicine. The AWP statute regulates the business of insurance because it satisfies the common-sense enquiry as well as an analysis of the three McCarran-Ferguson criteria that are used to assess whether a statute is saved from ERISA preemption. The AWP statute regulates the practice of medicine because it counteracts the scheme of assigning too many patients to any one doctor, which can create a high patient volume medical practice. The scheme of restricting physician membership and limiting the number of doctors in a health insurance network can increase the patient to physician ratio in individual physician practices. This can result in deleterious consequences for patients because any one patient may not receive the necessary attention, care and treatment by reasonable medical standards. The AWP statute also promotes continuity of patient care because under the statute, health insurers cannot deny membership to a doctor who wants to join a health insurer to which his patient has transferred. Continuity of care preserves the patient-physician

relationship, which has a salutary effect on the health care of patients. This scheme is subject to regulation by Kentucky under its police powers.

ARGUMENT

I. KENTUCKY'S AWP STATUTE IS NOT PREEMPTED BY ERISA BECAUSE IT DOES NOT "RELATE TO" AN EMPLOYEE BENEFIT PLAN.

Kentucky's AWP statute is only preempted by ERISA if it meets ERISA's express preemption provision, § 514(a), 29 U.S.C. § 1144(a). Section 514(a) provides in pertinent part:

> . . . this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan. . . .

The Sixth Circuit found Kentucky's AWP statute preempted by § 514(a) because it did "relate to" an EBP. *Ky. Assoc. of Health Plans, Inc. v. Nichols*, 277 F.3d 352, 363 (6th Cir. 2000). The Petitioners' Brief claims there is no serious dispute that Kentucky's AWP laws "relate to" EBPs. (Brief at p. 12.) However, ACLM submits the Sixth Circuit erred in this determination and this Court should find that Kentucky's AWP statute is not preempted by § 514(a) because it does not "relate to" an EBP.

This Court has addressed preemption claims with the starting presumption that Congress does not intend to supplant state law. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 654-55 (1995). Traditional preemption analysis begins with the text of the provision in question and moves on to the structure and purpose of the Act in which it occurs. *Id.* at 655. This Court observed in *Travelers* that

the language of § 514(a) is not particularly helpful in deciding preemption issues.

> If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for "[r]eally, universally, relations stop nowhere,"
> . . .

514 U.S. at 655.

To determine whether a law "relates to" an EBP, this Court has formulated a two part test under which a "law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a *connection with* or [2] *reference to* such plan." *California Div. of Labor Standards v. Dillingham Constr. N.A., Inc.*, 519 U.S. 316, 324 (1997) (internal quotations and citations omitted) (emphasis added). A careful analysis of Kentucky's AWP statute finds that it does not meet either of these prongs and therefore, is not preempted by ERISA.

A. Kentucky's AWP statute does not have a connection with an employee benefit plan.

The ACLM submits that Kentucky's AWP statute does not have a "connection with" an EBP sufficient to trigger ERISA preemption because it is does not directly affect any EBP, nor bear indirectly, but substantially, on any EBP.

1. Kentucky's AWP law does not directly affect any employee benefit plans.

In *Travelers*, this Court began its analysis of the "connection with" test by noting that: "For the same reasons that infinite relations cannot be the measure of preemption, neither can infinite connections." *Id.* at 656.

This Court found that it "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* In analyzing preemption this Court has noted several different purposes for ERISA.

In *Travelers,* this Court found Congress intended § 514(a),

> "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction."

Id. at 657-658, citing *Ingersoll-Rand*, 498 U.S., at 142.

In *Dillingham Construction*, this Court cited *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989) for the finding that:

> In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator.

519 U.S. at 326-327.

Certainly, this latter finding of congressional purpose is more consistent with ERISA's full name – Employee Retirement Income Security Act. However, Kentucky's AWP law is not directly related to either purpose.

In *Travelers,* this Court stated it had no problem finding the "relates to" test was met when state laws "mandated employee benefit structures or their administration." 514 U.S. at 657. The examples of such cases cited by this Court included: *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (New York law that required employers to provide certain benefits for pregnancy); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), (Pennsylvania law that prohibited employer plans to subrogate their employee's claims from a liable third party); and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (New Jersey law that prevented plans from calculating benefits using a method that was permitted by federal law). The common thread running through all of these cases was that the state had passed a statute, which *directly* required a plan to take (or not to take) certain action with regard to the provision of its benefits.

Kentucky's AWP law does not conflict with the goals of ERISA because it does not require any *employer* providing an EBP to do anything. It simply requires that all health insurance providers operating in Kentucky meet certain requirements. The analysis of this issue shows how the Petitioners miss a fundamental point.

As this Court noted in *Pegram v. Herdrich*, 530 U.S. 211, 227 (2000), **"The HMO is *not* the ERISA plan, . . ."** *Id.* (Emphasis added.) Applying this fundamental principle

to Kentucky's AWP statute finds that it is not preempted by ERISA.

Kentucky's AWP statute does not directly affect any EBPs that are covered by ERISA. No Kentucky employer is forced by this statute to offer a particular type of health care coverage as a benefit (or even any such coverage at all). If an employer does not offer health care coverage as a benefit the employer is not affected by the statute. If an employer offers a self-funded plan the employer is not affected by the statute. If an employer does purchase some type of health insurance benefits for its employees it is not told what type of benefits it must provide. Instead, the employer only finds when shopping for a health insurer that all of the health insurers who have sought the privilege of doing business in Kentucky have to comply with this statute.[2]

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[2] This position has been taken by many of the legal commentators examining this issue. *See*: William J. Bahr, *Although Offering More Freedom to Choose, "Any Willing Provider" Legislation is the Wrong Choice*, 45 U.Kan.L.Rev. 557, 582 (1996) (Any willing provider statutes do not regulate ERISA plans because there is only an indirect effect on ERISA plans and does not prevent a uniform administration of benefit plans.); Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 Yale J.Reg. 255, 331 (1996) ("Even if provided by the entity which also provides administration of plans for employers, the selection of network physicians should not be characterized as administration of an ERISA plan.); Justin Goodyear, *What is an Employee Benefit Plan?: ERISA Preemption of "Any Willing Provider" Laws After Pegram*, 101 Colum. L. Rev. 1107 (2001) (State laws that regulate the relationship between managed care organizations and health care providers should not be preempted by ERISA.); Dianne McCarthy, *Narrowing Provider Choice: Any Willing Provider Laws After New York Blue Cross v. Travelers*, 23 Am. J.L. & Med. 97, 107-108 (1997) ("Like the surcharges analyzed in New York

(Continued on following page)

Thus, any of the burdens imposed by Kentucky's AWP statute fall not on EBPs, but only on the health insurance companies who seek to do business in Kentucky by offering health insurance to EBPs. Because the HMO is not the ERISA plan, the AWP statute does not directly affect the ERISA plan.

2. Kentucky's AWP statute does not have an indirect, but substantial effect on any ERISA plans sufficient to find pre-emption.

As shown, Kentucky's AWP law is not preempted because it does not directly affect any ERISA plans. The Petitioners apparently concede this point because their Brief does not argue that the AWP statute directly affects ERISA plans. Instead, the Petitioners argue that AWP laws "bear indirectly but substantially on all insured benefit plans by precluding them from purchasing medical coverage from HMOs with limited provider networks." (Petitioners' Brief, p. 12.)

However, that argument would leave every Kentucky statute related to the provision of health care subject to ERISA preemption. For example, Ky. Rev. Stat. Ann. § 311.571 requires individuals to meet certain qualifications to be licensed physicians. Using the Petitioners' "analysis", this statute is preempted by ERISA, because it bears indirectly but substantially on all EBPs by precluding them from purchasing medical coverage from HMOs that use physicians who graduated from unaccredited schools. The absurdity of such a result is the reason this Court has recognized that a mere indirect, economic effect on an ERISA plan is not enough to preempt state law.

Blue Cross, "Any Willing Provider" laws indirectly affect ERISA plans, "Any Willing Provider" statutes neither function as a regulation of the plan itself, nor preclude uniform administrative practice or the provision of a uniform interstate benefit package. Furthermore, "Any Willing Provider" laws do not thwart the purpose of ERISA – to ensure that employee benefits plans are not required to alter their structure in response to individual state laws.")

In *Travelers*, this Court modified the "connection with" test by asking whether the law brought about an indirect economic effect that merely affected the rates charged by plans as opposed to the choices made by plan administrators. This Court found that "An indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . ." Instead, "It simply bears on the costs of benefits and the relative costs of competing insurance to provide them." 514 U.S. at 659-660. Further, this Court noted in *Travelers*:

> Indeed, to read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in § 514(a) out of the statute, a conclusion that would violate basic principles of statutory interpretation and could not be squared with our prior pronouncement that "[p]re-emption does not occur . . . if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S., at 130 n.1,

113 S.Ct., at 583 n.1 (internal quotation marks and citations omitted).

514 U.S. at 661.

Thus, in finding that the statute in issue was not preempted, this Court held:

> In sum, cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those "conflicting directives" from which Congress meant to insulate ERISA plans. See 498 U.S., at 142, 111 S.Ct., at 484. Such state laws leave plan administrators right where they would be in any case, with the responsibility to choose the best overall coverage for the money. We therefore conclude that such state laws do not bear the requisite "connection with" ERISA plans to trigger pre-emption.

514 U.S. at 662.

This Court adopted the same rationale in *Dillingham* and found the prevailing wage statute in issue was not preempted because:

> The wages to be paid on public works projects and the substantive standards to be applied to apprenticeship training programs are, however, quite remote from the areas with which ERISA is expressly concerned – "'reporting, disclosure, fiduciary responsibility, and the like.'"

519 U.S. at 331 (citations omitted).

The principle that indirect economic effects of a state statute are not sufficient to trigger ERISA preemption was articulated in *Washington Physicians Service Association*

v. Gregoire, 147 F.3d 1039 (9th Cir. 1998), which upheld a Washington law that mandated the inclusion of all categories of providers. In rejecting ERISA preemption, the court held:

> The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a regulation of health insurance automatically to "relate to" an employee benefit plan – just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to "relate to" employee benefit plans.

Id. at 1043.

This analysis is bolstered by the fact that ERISA is totally silent on this issue. This Court noted in *Dillingham*, "A reading of § 514(a) resulting in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling'." 519 U.S. at 331 (citations omitted). Because there is no conflict between the language of ERISA and Kentucky's AWP statute, it does not directly affect any EBPs.

Requiring health care insurers who have sought the privilege of doing business in Kentucky to include providers who are willing and able to meet all of their contractual requirements does not require EBPs to structure their benefits or conduct their internal affairs in any particular way. The AWP statute does not prohibit EBPs from offering coverage through a preferred provider organization or specify the terms of the provider contracts. The AWP statute does not impair a plan sponsor's ability to offer the same benefits to employees in different states. It does not require any ERISA plan to pay any benefit, any level of

benefit, or any particular amount of a patient's medical bill. In sum, it does not impose *any* substantive requirements on ERISA plans.

Just as this Court in *Dillingham* found that California's prevailing wage statute for contractors did " . . . not dictate the choices facing ERISA plans." 519 U.S. at 334, this Court should find that Kentucky's AWP law for health insurance carriers does not dictate the choices facing ERISA plans.

Thus, because Kentucky's AWP statute does not directly relate to any employee benefit plan it is not preempted by ERISA.

B. Kentucky's AWP statute does not make sufficient reference to an employee benefit plan to trigger preemption.

Here, the Sixth Circuit found that the "reference to" test was met because:

> under Kentucky's statute, "health benefit plans" were defined to include, among other things, "a self-insured plan or plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA."

Nichols, at 359.

This Court has held that: "Where a State's law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law's operation, as in *Greater Washington Bd. of Trade* and *Ingersoll-Rand*, that 'reference' will result in pre-emption." *Dillingham*, 326. Thus, this Court has found the "reference to" provision triggered preemption in

certain cases: *Greater Washington Bd. of Trade*, *supra*, at 130-131 (law that "impos[ed] requirements by reference to [ERISA] covered programs,"; *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 828, n.2, 829-830, (1988) (law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990) (common-law cause of action was premised on the existence of an ERISA plan).

The Sixth Circuit's holding ignores the *Dillingham* analysis. The reference to ERISA in Kentucky's AWP statute does not trigger preemption because it does not cause the law to act immediately and exclusively upon ERISA plans, nor is the existence of an ERISA plan essential to the law's operation.

The Sixth Circuit noted but rejected Kentucky's argument that the statute's definition merely restated "the 'deemer clause' by exempting self-insured ERISA plans from the scope of the AWP statute." *Nichols*, at 361. (The 'deemer clause' of ERISA, § 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), prevents states from regulating self-insured plans under the guise of regulating insurance. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).) The ACLM submits the Sixth Circuit erred by rejecting this argument.

The use of the term "ERISA" in Kentucky's AWP statute does not single out ERISA plans for differing treatment as in *Mackey* or refer to such plans because they are necessary for its operation, as in *Greater Washington Board of Trade*. Rather, it simply acknowledges the limits on the scope of state laws imposed by the deemer clause. Thus, Kentucky's AWP law treats all insurers and all

plans (ERISA and non-ERISA) alike to the extent permitted by federal law. If just the use of the term "ERISA" was, by itself, sufficient to warrant preemption, it would create the perverse result that Kentucky's express acknowledgment of the limits imposed by the deemer clause would render the AWP law preempted. Under that scenario two different states could pass two identical statutes, except that one expressly acknowledged the deemer clause. One statute would be preempted and one would not. The inconsistency of such a result shows that the "reference to" test is not met simply because a statute uses the word "ERISA" somewhere in its text. Otherwise, determining whether a state's statute is preempted by ERISA would be more like searching through an ancient text for a magic talisman instead of engaging in a careful and logical analysis of its history and purpose.

This approach was used by the court in *United Wire, Metal & Mach. Health and Welfare Fund v. Morristown Mem'l Hospital*, 995 F.2d 1179 (3d Cir. 1993). In that case, it was argued that a statute was preempted because it expressly referred to "self funded union plans" as an example of a "third party payor". The court rejected that "magic words" argument, and held that "Where, as here, a reference to an ERISA plan can be excised without altering the legal effect of a statute in any way, we believe the reference should be regarded as without legal consequence for [preemption] purposes." *Id.* at 1192, n.6. Similarly, the court in *Thiokol Corporation, Morton International Inc. v. Roberts*, 76 F.3d 751, 760 (6th Cir. 1996), held that "the underlying purpose of ERISA preemption . . . is to prevent impermissible effects, not references."

Indeed, the District Court in *Community Health Partners, Inc. v. Nichols*, 14 F. Supp. 2d 991 (W.D.Ky. 1998), adopted this analysis:

> In the present case, on the other hand, the existence of employee benefit plans is not *essential* to the operation of Kentucky's AWP law. By definition, the statute applies to the contracts or "plans" by which certain entities assume financial risk for various health-related occurrences. Although ERISA self-insured employee welfare benefit plans and MEWAs are among the risk-bearing entities referenced in the statute, these ERISA plans are by no means the *only* entities affected by the statute. Moreover, although the non-ERISA entities – such as insurance companies and HMOs – defined in the statute primarily contract directly with insured ERISA plans, they also contract with private individuals and groups not affected by ERISA. Thus, it does not meet the requirements of the "reference to" test.

Id. at 996.

The ACLM submits that an ERISA preemption analysis should do more than look for the "magic word". Although Kentucky's AWP statute uses the word ERISA, it only does so to acknowledge the existence of the deemer clause. This statute does not use the term in order to act exclusively upon ERISA plans. Thus, this Court should find that the "reference to" test has not been met.

II. KENTUCKY'S AWP STATUTE IS SAVED FROM PREEMPTION BECAUSE IT REGULATES THE BUSINESS OF INSURANCE IN ORDER TO REGULATE THE PRACTICE OF MEDICINE.

Alternatively, should this Court find that there is preemption, then the Kentucky AWP statute regulates the business of insurance in order to regulate the practice of medicine and thus is saved from ERISA preemption. The AWP statute regulates the business of insurance because it targets "health insurers." Ky. Rev. Stat. Ann. § 304.17A-270. § 304.17A-005(23) defines these entities. The term health insurer includes hybrid organizations composed to arrange and provide health care as well as to insure subscribers for the risk of illness. This Court has stated in *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151 (2002) that an HMO " . . . provides health care, and it does so as an insurer" *Id.* at 2160, and that " . . . virtually all commentators on the American health care system describe HMOs as a combination of insurer and provider." *Id.* at 2161. Also, "Nor do we see anything standing in the way of applying the saving clause if we assume that the general state definition of HMO would include a contractor that provides only administrative services for a self-funded plan." *Id.* at 2162. Here, the term health insurer is used interchangeably with the term managed care organization ("MCO"). Managed care organizations include health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), exclusive provider organizations, and certain integrated health care delivery systems. See Barry R. Furrow, et al., *Health Law* Sec. 8-1 (1995), Larry J. Pittman, *"Any Willing Provider" Laws and ERISA's Saving Clause: A New Solution For An Old Problem*, 64 Tenn. L. Rev. 409, 412 n.11 (1997).

The AWP statute regulates the business of insurance under the same common sense analysis used in *Rush Prudential*, 122 S. Ct. 2151, 2159-2163. The statute is directed at insurer MCOs and concerns itself with the composition of their physician networks that deliver the care obligations to the patients who are MCO subscribers. It mandates that these health insurers, licensed by and under the regulation of the Respondent, Kentucky Department of Insurance, open up their restrictive physician panels to any Kentucky licensed physician who is willing to meet the terms and conditions of the MCO. The statute does not control these terms and conditions. The statute targets essentially the same entities as the independent review statute in *Rush Prudential*.

The statute also passes the three McCarran-Ferguson tests. First, the statute does target the spreading of risk between the health insurer and the patient insured, although it is not necessary to satisfy this risk-spreading prong to find the statute is saved from preemption. *Rush Prudential*, 122 S. Ct. 2151, 2163. The patient's employer pays a fee to cover the risk of illness in return for the promise of a care obligation. If the patient gets ill, the health insurer then fulfills its care obligation. The care obligation, which is the actual performance of the insurance contract, is inextricably intertwined with the composition of the physician network. This Court has stated, "There can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance,' as we understood that phrase in *Pireno* and *Royal Drug*." *United States Dept. of Treasury v. Fabe*, 508 U.S 491, 503 (1993). Under the AWP statute, the risk of not having the most appropriate doctors in the network for the patient's specific circumstance is reduced and spread to the insurer

who must accept any willing provider. Second, the AWP statute regulates an integral part of the policy relationship between the insurer and the insured, i.e. who will perform the care obligation because patients are basically concerned with which doctors in their MCO network they can choose for their care. The third factor is satisfied based on the analysis in *Rush Prudential*, 122 S. Ct. 2151, 2164. Finally, ACLM agrees with the suggestion that this Court find that state AWP laws avoid preemption if they were enacted for "the purpose of" regulating the business of insurance. Larry J. Pittman, *"Any Willing Provider" Laws And ERISA's Saving Clause: A New Solution For An Old Problem*, 64 Tenn. L. Rev. 409, 496 (1997). Accordingly, the AWP statute regulates the business of insurance.

Moreover, the AWP statute regulates health insurers and their business of insurance in order to regulate the practice of medicine. This statute can increase the number of doctors in the health insurer's network of physicians, which promotes patients having a greater choice of physicians and more access to their preferred physician. This statute also counteracts the scheme of assigning too many patients to any one doctor such that their practice will have an excessive volume of patients. Under the AWP statute patients are more likely to receive the care and attention they require when going to their doctor with health problems. In *Rush Prudential* 122 S. Ct. 2151, this Court concluded: "States regulate insurance in looking out for the welfare of their citizens," *Id.* at 2170 and " . . . regulating insurance tied to what is medically necessary is probably inseparable from enforcing the quintessentially state-law standards of reasonable medical care," *Id.* at 2171. The Court also noted: "Illinois has chosen to regulate insurance as one way to regulate the practice of medicine,

which we have previously held to be permissible under ERISA, see *Metropolitan Life*, 471 U.S., at 741." *Id.* at 2170-71.

A. Kentucky has a legitimate interest under its police powers in regulating the health insurer's restrictive physician membership policy.

The power to regulate the practice of medicine is traditionally reserved to the states through their ability to regulate health care absent clear expressed Congressional intent to the contrary. See *Travelers*, 514 U.S. 645 (1995), *Dillingham*, 519 U.S. 316 (1997), and *Rush Prudential*, 122 S.Ct. 2151 (2002).

States derive their authority to regulate health care from the state police power, which is derived from the Tenth Amendment. See *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905). As states can best assess the health needs of their own citizens and enact laws to address those needs, health care is "primarily, and historically, a matter of local concern." *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707, 719 (1985). This Court has worked on the assumption that the historic police powers of the States were not to be superseded by ERISA "unless that was the clear and manifest intent of Congress." *Travelers*, 514 U.S. 645, 655 (1995). In *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806, 814 (1997), this Court noted that Congress did not intend for § 514 of ERISA to displace general health care regulation, an area traditionally of local concern. It has also been observed that, "The misuse of ERISA preemption clearly usurps the state's power to protect its citizens." Marilyn Lablaiks, *Bad Medicine: ERISA's Equitable Remedies and*

the Preemption of Fundamental Legal Rights, 34 J. Marshall L. Rev. 583, 609 (Winter 2001).

The AWP statute is a health care regulation, which encompasses the practice of medicine to promote the health and safety of Kentucky's citizens by allowing more physicians to serve a given patient population. This Court has affirmed that: "In the ordinary case, a law will be sustained if it can be said to advance a legitimate government interest, even if the law seems unwise or works to the disadvantage of a particular group, or if the rationale for it seems tenuous." *Romer v. Evans*, 517 U.S. 620, 632 (1996). "But it is for the legislature, not the courts, to balance the advantages and disadvantages of the new requirement." *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 487 (1955). Although the Petitioners and their *amici* make several public policy arguments against this statute, the fact is that the Kentucky Legislature is free to make the policy choices it deems best as long as those choices are not legally preempted by ERISA.

The Petitioners' Brief on page 2 claims that: "In exchange for their rate discount, participating providers receive the advantage of access to the HMOs' subscribers and, consequently, increased patient volume over non-network providers who lack such access." Further, "the value of network membership (and, accordingly, the amount providers will agree to discount their services) depends on the HMOs' ability to limit the number of providers in the network; the fewer the providers, the greater the patient volume for each provider."

However, ACLM believes Kentucky has a legitimate interest to regulate the practice of medicine and protect its citizens regarding the number of physicians in an MCO

panel, which relates to the volume of patients in a medical practice. As a matter of common sense, a high volume of patients with discounted professional fees could have a direct effect on the health care that patients receive. The higher volume can make it more difficult for patient's phone calls to get through to their doctors; make it longer to get in for an appointment; and make the patient have to wait longer to get into the examination room. Less time will be available to obtain a complaint, history of present illness, and to acquire or refresh the doctor's knowledge regarding medical history, medications, and allergies. Less time will also be available to conduct an examination, formulate a diagnosis, decide on what tests should be ordered and what treatments should be prescribed. All of these factors obviously impact on the practice of medicine.

Two cases are illustrative of this point. In *Jones v. Chicago HMO Ltd. of Illinois*, 730 N.E.2d 1119 (Ill. 2000), the plaintiff charged the HMO with institutional negligence for negligently assigning the doctor as the child's primary care physician while he was serving an overloaded patient population. The court decided that the HMO owed a duty to refrain from assigning an excessive number of patients to the contract primary care physician. The court noted: "Public policy would not be well served by allowing HMOs to assign an excessive number of patients to a primary care physician and then wash their hands of the matter." *Id.* at 1134. Further, the court recognized that " . . . HMO accountability is needed to counterbalance the HMO goal of cost containment and, where applicable, the inherent drive of an HMO to achieve profits." *Id.*

The second case, *Thomas W. Self, M.D. v. Children's Associated Medical Group* (695870) litigated in San Diego County Superior Court in 1998, also illustrates the

problems that can occur in "high volume – low cost" medical practice. Kathy Kinsey, *Settlement Helps Patch Up Physician's Firing*, Verdicts & Settlements Supplement to the Los Angeles Daily Journal, 1, 4, 8 (June 26, 1998).

In his lawsuit for wrongful termination from a medical group that had a large HMO practice, Dr. Thomas Self alleged that he was terminated because he was spending too much time with his patients. *Id.* at 1. A jury awarded $1.75 million in compensatory damages. *Id.* at 4. Dr. Self was the first doctor to win a case under the California law that prohibits retaliation against doctors for advocating appropriate patient care. *Id.* Spending adequate time with a patient is one example of appropriate patient care that is difficult to do in a high volume practice. Dr. Linda Daniels, chairwoman of the San Diego Medical Society's bioethics committee, stated: "Where health plans are saying you (the doctor) must see six to eight patients an hour, they are setting up a situation where you just can't practice good medicine. Good medicine requires good communication, as well as merely doing an exam or checking a blood pressure. . . . In (just a few) minutes, how in the world are you going to get to know the patient?" Julie Marquis, *Verdict for Doctor in HMO Case Hits Nerve*, Los Angeles Times, A1, A24 (April 15, 1998). In October of 1999, the Journal of Health Politics, Policy and Law published a special issue, *The Managed Care Backlash*. It was noted that one of the reasons for this "backlash" was the widespread public concerns about the effect of managed care on quality and access to care. Mark A. Peterson, *Introduction: Politics, Misperception, or Apropos?*, 24 J. Health Pol., Poly. & Law 876 (1999). Certainly, the citizens of Kentucky, through their legislature, are able to allay these concerns by enacting an AWP law. These examples support the logic that Kentucky has a legitimate interest in

regulating health insurers that are involved in determining the number of physicians who will practice medicine in a given network.

The Petitioner's argument could create the incongruous situation that a state can mandate nurse-to-patient ratios at hospitals but cannot pass AWP statutes to achieve the goal of increasing the doctor-to-patient ratio by trying to provide for a greater number of doctors in MCO panels. California has passed a "Safe Staffing Law" pertaining to hospital nurse-to-patient ratio requirements because of concerns that " . . . quality of patient care is jeopardized because of staffing changes implemented in response to managed care." 30 *J. Law, Med & Ethics* 312 (2002); See Linda H. Aiken, et al., *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction*, 288(16) J.A.M.A. 1987 (2002). There have been recent reports of patient deaths being linked to nursing shortages, i.e. high patient-to-nurse ratios. Dr. Dennis S. O'Leary, President of the Joint Commission on Accreditation of Healthcare Organizations, stated: "We knew that some unanticipated deaths and permanent loss of function were related to inadequate numbers of nurses, but 24 percent surprised everybody." Sheryl Gay Stolberg, *Patient Deaths Tied to Lack of Nurses*, N.Y. Times, A-18 (August 8, 2002). Although there is no evidence in the record of this case that restrictive physician panels have resulted in patient deaths, ACLM does not believe that Congress intended ERISA to proscribe state laws regulating the supply of doctors while allowing state laws to regulate the supply of nurses.

Opponents of AWP statutes could argue that smaller panels of doctors allow those in the panel to receive more training and experience so as to maintain and improve

their expertise. However, in one case a woman who developed liver cancer was denied coverage to see a surgeon out of network who specialized in liver cancer surgery. Instead, the MCO referred the patient to surgeons who had never performed the specialized surgery and the patient died while fighting the MCO's decision. Elisabeth Rosenthal, *Complications In Care – A Special Report: Patients With Difficult Illnesses Fight New HMO's To Get Help*, N.Y. Times A1 (July 15, 1996). In another case, a patient's parents were forced to go outside the MCO network after the MCO referred her to a surgeon with no experience in treating the type of kidney cancer she had. *Commissioner of Corps. of Cal. v. TakeCare Health Plan, Inc.*, No. 933-0290 (Cal. Dep't of Corps. Oct. 11, 1996). The AWP statute makes it more likely that an insurer's panel would include certain doctors with unique skills and expertise.

Further, even though the Petitioners claim AWP laws infringe upon an MCO's ability to control the quality of the providers, this claim has been refuted. Most MCO's use indirect measures of quality and efficiency, instead of using stringent, objective performance criteria. Robert J. Shouldice, *Introduction to Managed Care* 74 (1991). "But if there were an objectively correct method, every plan should include (or exclude) the same providers. Obviously, the managers of different plans disagree, and none will admit being wrong." Joseph White, *Choice, Trust, and Two Models of Quality*, 24 J. Health Pol., Poly. & Law 996 (1999). The fact that a preferred panel is not assembled based on objective quality measures is a legitimate reason for Kentucky to enact an AWP law, so that consumers are free to make their own judgments about the relative quality of providers.

Thus, the scheme of directing high volumes of patients to limited numbers of doctors in an effort to lower the cost of care and maximize the MCO's profit is subject to state regulation such as the AWP statute because it involves the practice of medicine.

B. Kentucky has a legitimate interest under its police powers in regulating the continuity of care that its citizens receive from their doctors.

"The doctor/patient relationship is an important and special relationship, vital to the provision of health care. It develops over time, by a doctor learning a patient's history and exercising professional judgment in not only evaluating a patient's complaints, but in developing a specific strategy for treating a patient's ailments. Consequently, an individual's choice of doctor is of great importance." *Humana Medical Plan, Inc. v. Ira S. Jacobson, M.D.*, 614 S.2d 520, 522 (Fla. App. 3rd Dist. 1992). Moreover, "when an ailing person selects a physician to treat him, he does so with the full expectation that such physician will do his best to restore him to health, and the contract into which they enter is deserving of more attention from the law than a businessman's expectation of profit from a purely commercial transaction." *Hammonds v. Aetna Casualty & Surety Co.*, 237 F. Supp. 96, 101 (N.D. Ohio 1965).

Patients may change health insurers for a variety of reasons and this may jeopardize the continuity of care, which is important to quality health care. Ezekiel J. Emanuel and Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 J.A.M.A. 323, 327 (1995). The patient's subsequent health insurer may provide a restricted panel of

doctors, which does not include the patient's original physician, thus fostering discontinuity of care. ACLM submits that patients will more likely retain their doctor of choice under Kentucky's AWP statute if the patient's health insurer changes.

Continuity of care (being under the care of the same physician for health needs) is fundamental to the doctor-patient relationship and has a direct nexus to the practice of medicine. The cornerstone of the practice of medicine is the doctor-patient relationship because doctors cannot practice medicine without patients. See David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 Health Matrix Journal of Law Medicine 141, 143 (Winter 1995).

Maintaining continuity of care with their usual physician is important to many patients. Margaret M. Love and Arch G. Mainous III, *Commitment to a Regular Physician: How Long Will Patients Wait to See Their Own Physician for Acute Illness?*, 48 The Journal of Family Practice 202 (1999). "Forced disruption of continuity of care is detrimental to patient receipt of primary care, and is a potential negative consequence of annual bidding for managed care contracts." Susan A. Flocke, *The Impact of Insurance Type and Forced Discontinuity on the Delivery of Primary Care*, 45 The Journal of Family Practice 129, 133-134 (1997).

MCO restrictions on physicians who are qualified and willing to meet the terms and conditions of the MCO interfere with the bond between patients and their doctors. Ezekiel J. Emanuel and Nancy Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed*

Care, 273 J.A.M.A. 323, 327 (1995). The selective contracting scheme that the Petitioners advocate and the Commonwealth of Kentucky has reformed may lead to patient dissatisfaction. Christopher B. Forrest, et al., *Managed Care, Primary Care, and the Patient-practitioner Relationship*, 17(4) Journal of General Internal Medicine 270 (2002). Indeed, Jeff Goldsmith, a University of Virginia associate professor and health care industry consultant, spoke at a session on health care in Louisville, Kentucky on August 21, 2002 sponsored by Humana, Inc., the parent company of two of the Petitioners. Patrick Howington, *Rising Costs Means Health-Insurance Change*, Courier-Journal, B1 (August 23, 2002). Goldsmith stated that consumers demand health plans with a wide choice of providers. *Id.* Furthermore, changes in health care systems that promote discontinuity (such as when an employer switches to a plan that a patient's qualified physician cannot join) can be particularly disruptive for patients with chronic diseases, especially asthma. Margaret Love, et al., *Continuity of Care and the Physician-Patient Relationship*, 49 The Journal of Family Practice 998, 1004 (2000).

Indubitably, continuity of care is associated with a higher level of trust between patient and physician. Audiey C. Kao, et al., *Patients' Trust In Their Physicians*, 13 Journal General Internal Medicine 681, 685 (1998) and thus the doctor-patient relationship has been described as a moral covenant between physician and patient. Mark O. Hiepler and Brian C. Dunn, *Irreconcilable Differences: Why The Doctor-Patient Relationship Is Disintegrating At The Hands Of Health Maintenance Organizations And Wall Street*, 25 Pepperdine L. Rev. 597 (1998). There has been widespread agreement that trust between patient

and physician is important for high-quality health care. Arch G. Mainous III, et al., *Continuity of Care and Trust in One's Physician: Evidence from Primary Care in the United States and the United Kingdom*, 33 Family Medicine 22, 27 (2001).

Forced discontinuity caused by insurance changes not only has an impact on patients' quality of care, but can also lead to extra visits and hidden costs. George E. Kikano, et al., *'My Insurance Changed': The Negative Effects of Forced Discontinuity of Care*, Family Practice Management, http://www.aafp.org/fpm/20001100/44myin.html. Preliminary studies suggested that long-standing doctor-patient ties foster less expensive, less intensive medical care. Linda J. Weiss and Jan Blustein, *Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans*, 86 American Journal of Public Health 1742 (1996). Additionally, continuity has been associated with a lower likelihood of future hospitalization, which would lower the cost of care for the MCO. James M. Gill and Arch G. Mainous III, *The Role of Provider Continuity in Preventing Hospitalizations*, 7 Archives of Family Medicine 352, 357 (1998).

Hence, continuity of care is directly linked to the practice of medicine, which Kentucky has the power to regulate. When a patient is forced to a different health insurer that the patient's qualified physician cannot be a part of, even though that physician is willing to meet the terms and conditions of the health insurer, then Kentucky has a legitimate interest in addressing this discontinuity

of care. The AWP statute is a legitimate way for the state to do so.

CONCLUSION

At the end of the day, it should be noted that equally important to the legal analysis which this Court will undertake before arriving at a decision will be application of the analysis, pragmatically, on consumers as patients who seek and who are provided health care and treatment in today's era of health care delivery. Though the tentacles of managed care are embedded within such delivery, the *sine qua non* for quality and timely delivery is not consistent with the views advocated by Petitioners. This case presents, then, yet another foray before this Court (see *Rush Prudential*) to subvert a state's attempt to provide its citizenry with a process that promotes quality, timely and adequate health care. This *amicus* has demonstrated that any willing provider statutes are a mechanism to promote quality medical care by maximizing the number of health care practitioners available to patients within the Commonwealth of Kentucky.

Consequently, Kentucky's AWP statute does not have a relation with ERISA sufficient to invoke preemption; but even if there is a nexus between these state and federal laws here giving birth to preemption, the AWP statute at issue is saved from ERISA's preemptive reach because it (AWP) regulates the business of insurance by regulating the practice of medicine.

WHEREFORE, for all the foregoing reasons, *amicus curiae*, the American College of Legal Medicine, urges this

Court affirm the judgment rendered by the Sixth Circuit Court of Appeals.

Respectfully submitted,

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